
State:	Arkansas	Filing Company:	United Life Insurance Company
TOI/Sub-TOI:	L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life		
Product Name:	VIP App		
Project Name/Number:	/		

Filing at a Glance

Company:	United Life Insurance Company
Product Name:	VIP App
State:	Arkansas
TOI:	L09I Individual Life - Flexible Premium Adjustable Life
Sub-TOI:	L09I.001 Single Life
Filing Type:	Form
Date Submitted:	11/30/2012
SERFF Tr Num:	UNFG-128769133
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	LIU-620 (1-13)
Implementation	01/01/2013
Date Requested:	
Author(s):	Joanne Young
Reviewer(s):	Linda Bird (primary)
Disposition Date:	12/05/2012
Disposition Status:	Approved-Closed
Implementation Date:	
State Filing Description:	

State: Arkansas **Filing Company:** United Life Insurance Company
TOI/Sub-TOI: L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life
Product Name: VIP App
Project Name/Number: /

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 12/05/2012
State Status Changed: 12/05/2012
Deemer Date: Created By: Joanne Young
Submitted By: Joanne Young Corresponding Filing Tracking Number:

Filing Description:

MIB REQUIRED CHANGE TO MID AUTHORIZATION EFFECTIVE 1/1/2013

LIU-620 (1-13) Application for Life Insurance

We are filing a revised application to be used with our Voluntary Insurance Program. This form will replace form LIU-620 (4-09) which was approved by your office on 2/11/2009. That was SERFF number UNFG-126026332.

The only revision from the LIU-620 (4-09) form is the MIB required change effective 1/1/2013. I have attached, in the supporting documentation tab, the (4-09) version with a redling showing what text was removed and the (1-13) version with highlighted text showing what was added. the change is on page 3 of the form. No other changes have been made to the form except to revise the form number.

Company and Contact

Filing Contact Information

Joanne Young, Analyst jyoung@unitedfiregroup.com
118 2nd Ave SE 319-286-2620 [Phone]
PO Box 73909 319-286-2570 [FAX]
Cedar Rapids, IA 52407-3909

Filing Company Information

United Life Insurance Company	CoCode: 69973	State of Domicile: Iowa
118 2nd Ave SE	Group Code: 248	Company Type: Life
PO Box 73909	Group Name: United Fire Group	State ID Number:
Cedar Rapids, IA 52407-3909	FEIN Number: 42-6061188	
(319) 399-5700 ext. [Phone]		

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

SERFF Tracking #: UNFG-128769133

State Tracking #:

Company Tracking #: LIU-620 (1-13)

State: Arkansas

Filing Company: United Life Insurance Company

TOI/Sub-TOI: L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life

Product Name: VIP App

Project Name/Number: /

Company	Amount	Date Processed	Transaction #
United Life Insurance Company	\$50.00	11/30/2012	65331177

SERFF Tracking #:	UNFG-128769133	State Tracking #:		Company Tracking #:	LIU-620 (1-13)
State:	Arkansas	Filing Company:	United Life Insurance Company		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/05/2012	12/05/2012

SERFF Tracking #:	UNFG-128769133	State Tracking #:		Company Tracking #:	LIU-620 (1-13)
State:	Arkansas	Filing Company:	United Life Insurance Company		
TOI/Sub-TOI:	L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life				
Product Name:	VIP App				
Project Name/Number:	/				

Disposition

Disposition Date: 12/05/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Form	Application for Life Insurance		Yes

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Product Name:	VIP App		
Project Name/Number:	/		

Form Schedule

Lead Form Number: LIU-620 (1-13)								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Life Insurance	LIU-620 (1-13)	AEF	Initial		0.000	LIU-620 (1-13).pdf

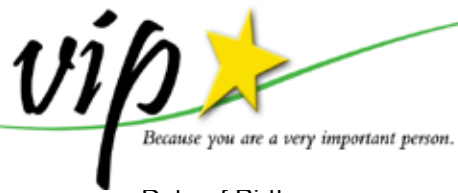
Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



VIP PROGRAM—APPLICATION FOR LIFE INSURANCE
UNITED LIFE INSURANCE COMPANY
P.O. Box 73909 – Cedar Rapids, Iowa 52407
800-637-6318 FAX 888-726-9736

VOLUNTARY INSURANCE PROGRAM



Proposed Insured Name _____ Date of Birth _____ Age _____
Street Address _____ Sex ☐ Male ☐ Female
City _____ State _____ Zip _____
Soc.Sec. # _____ U.S. Citizen ☐ yes ☐ no Home Phone # _____
Occupation _____ Employer _____ Work Phone # _____
Have you smoked cigarettes in the past 12 months? ☐ yes ☐ no Driver's License # _____

Owner _____ Tax ID/SS Number _____
Address _____ City _____ State _____ Zip _____
Phone Number _____ U.S. Citizen ☐ yes ☐ no

FACE AMOUNT \$ _____ **PREMIUM \$** _____ per month

OPTIONAL RIDERS

Limited Disability Income	\$500	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(minimum face amount required \$25,000)
	\$1000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(minimum face amount required \$50,000)
Children's Term	\$10,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

APPLICATION FOR CHILDREN'S COVERAGE (Children of the proposed insured who have not reached their 19th birthday.)

Name	DOB	Injury, illness or history of medical problems within the past 5 yrs.?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have any of these children applied or been examined for life, accident or health insurance that was declined or modified as to rate or amount? ☐ Yes ☐ No If yes, give details.

Provide doctor's name and address. _____

BENEFICIARY DESIGNATION (will be Revocable and Per Stirpes if not indicated.)

PER STIRPES—if a named beneficiary dies prior to the insured, proceeds will be paid to the surviving direct descendants of that beneficiary. **PER CAPITA**—if named beneficiary dies prior to the insured, proceeds that would have been paid to that beneficiary will be divided equally among the other surviving named beneficiaries of that same class.

Primary ☐ Revocable or ☐ Irrevocable
☐ Per Stirpes or ☐ Per Capita

1. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

2. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

Contingent ☐ Revocable or ☐ Irrevocable
☐ Per Stirpes or ☐ Per Capita

1. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

2. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____

When we use the words “you” or “your” in this application, we mean Proposed Insured.

MEDICAL

1. (A) Ht. _____ ft. _____ in. Wt _____
2. Provide the name, address and phone number of your personal physician along with the date and reason last seen.
Dr. Name _____ Phone _____
Address _____
Date and reason last seen: _____
3. Have you ever applied for or been examined for life, accident or health insurance that was Yes No
declined or modified as to rate or amount? ☐ ☐
4. Have you ever had or been told by a medical practitioner that you have the following:
 - A. Respiratory or lung disease, brain, nervous or mental disease, depression or anxiety, seizures or sleep apnea? ☐ ☐
 - B. Liver disease, colitis, diabetes, sugar in urine, cancer, tumor, disease of the prostate, kidney or urinary tract? ☐ ☐
 - C. High blood pressure, chest pain, heart disease, arrhythmia, stroke or other cardiovascular disease? ☐ ☐
 - D. Back, bone or joint pain, arthritis, Alzheimer's or Parkinson's disease, muscular disease or paralysis? ☐ ☐
 - E. Alcohol or drug problems? ☐ ☐
 - F. Chronic diarrhea, abdominal disease, blood, gland, spleen or skin disease? ☐ ☐
5. Have you been diagnosed or treated by a medical professional for an immune deficiency disorder? HIV, AIDS or ARC? (In Wisconsin, the reporting of HIV tests is limited to the positive results of FDA licensed tests, and AIDS tests results obtained at anonymous counseling and testing sites are confidential and need not be disclosed) ☐ ☐
6. During the past five years have you used or do you now use barbituates, amphetamines, narcotics, hallucinogens, marijuana, cocaine or any prescription drug except by physician's prescription? ☐ ☐
7. Have you taken any prescription medication during the last 12 months? ☐ ☐
8. Any other accident, injury, operation or medical attention within the past five years not stated above? ☐ ☐
9. Have you been unable to work during the past three years due to illness or accident? (Disregard minor non-recurring illnesses.) ☐ ☐
10. During the past three years have you been charged with three or more moving vehicle violations or during the past five years been convicted of a DWI or DUI? ☐ ☐
11. Have you taken any aerial flight other than as a fare-paying passenger on a commercial airline? ☐ ☐
12. Do you participate in any hazardous avocation, occupation or sport? ☐ ☐
13. Have you been convicted of or pled guilty or no contest to a felony in the past ten years? ☐ ☐
14. Have you had a parent or sibling die prior to age 60 due to heart disease, diabetes or cancer? ☐ ☐
15. Do you have existing insurance or annuity contracts with this or any other company? ☐ ☐
16. Is this insurance intended to replace existing insurance or annuity with this or any other company? ☐ ☐
17. Do you intend to travel outside the United States for reasons other than recreational purposes? ☐ ☐

Explain any “YES” answers to the above questions. Provide details, dates, diagnosis, reason for prescriptions, etc.

IRS Taxpayer Certification

Under penalties of perjury, I (we) as Policy Owner(s), certify: (1) that the number(s) shown on this application is my correct Social Security or Taxpayer Identification Number (TIN) (or I (we) am waiting for a number to be issued to me), (2) I (we) am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) I (we) am a U.S. person(s) (including a U.S. resident alien).

Medical Authorization

I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, employer, or the Medical Information Bureau, Inc., to give United Life Insurance Company all information from the past 10 years that it holds, that pertains to medical consultations, treatments, surgeries, and hospital confinements including, but not limited to, HIV testing (limited to FDA approved tests; HIV test results received from an alternate test site or a home test kit need not be revealed) and the diagnosis and treatment of communicable disease, ARC, AIDS, chemical dependency or psychiatric illness concerning my physical and mental condition and employment records. This otherwise protected information is to be disclosed so that United may underwrite my application for coverage, obtain reinsurance, and conduct any other legally permissible activities related to my coverage. I authorize United Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. The MIB is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. United Life Insurance Company or its reinsurers may also release information to other life insurance companies to whom I apply for life or health insurance.

This Authorization shall be in force for 24 months following the date of my signature, except in Arizona, where the authorization to disclose HIV related information shall be in force for 180 days. I understand I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to United Life at 118 Second Avenue SE, Cedar Rapids, Iowa 52407. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of the above providers has relied on this Authorization or to the extent that United Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that if I refuse to authorize release of my complete medical record, United Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

I acknowledge that I have received a copy of this Authorization and I agree that a photocopy of this Authorization shall be as valid as the original.

Acknowledgement

I (we) have read this application in its entirety. I (we) verify that the statements and answers provided are true and complete to the best of my knowledge and belief and are to be considered as the basis for any insurance written as a result of this application. All statements are deemed representations and not warranties.

“Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.”

City and State where signed _____ Date _____

X _____

SIGNATURE OF PROPOSED INSURED
(or parent if Proposed Insured is a minor)

X _____

SIGNATURE OF OWNER IF OTHER THAN PROPOSED INSURED

I the agent, certify that to the best of my knowledge, the proposed insured ☐ does or ☐ does not have existing life policies or annuity contracts and that replacement ☐ is or ☐ is not involved in this transaction.

I the agent, certify that I have 1) used only insurer-approved or provided sales material, 2) left a copy of all sales material, 3) verified the identity of the owner/applicant.

X _____

SIGNATURE OF AGENT

AGENT'S PRINTED NAME

_____% _____%
AGENCY NAME AGENCY NUMBER AGENCY NAME AGENCY NUMBER



United Life Insurance Company
P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

NOTICES TO APPLICANTS
AGENT: GIVE TO APPLICANT IN EVERY CASE

The processing of your application and future insurance transactions may include a routine inquiry by United Life Insurance Company. This inquiry, if made, may provide applicable information concerning character, general reputation, personal characteristics, personally identifiable financial information and mode of living except as may be related directly or indirectly to the proposed insured(s) sexual orientation. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Information regarding the proposed insured(s) insurability will be treated as confidential. United Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from the proposed insured(s), MIB will arrange disclosure of any information it may have on file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

United Life Insurance Company or its reinsurers may also release information in their file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The Company will make such other disclosures as are permitted by law. Information for consumers about MIB may be obtained on its website at www.mib.com.

SERFF Tracking #:	UNFG-128769133	State Tracking #:		Company Tracking #:	LIU-620 (1-13)
State:	Arkansas	Filing Company:	United Life Insurance Company		
TOI/Sub-TOI:	L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life				
Product Name:	VIP App				
Project Name/Number:	/				

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Cert.pdf			

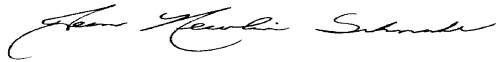
CERTIFICATE OF COMPLIANCE

UNITED LIFE INSURANCE COMPANY

Form number: LIU-620 (1-13) Application for Life Insurance

I hereby certify to the best of my knowledge and belief that this filing is in compliance with Arkansas Regulations 19 and 49 and Bulletin 11-88.

Certified by:



Jean Newlin Schnake, Secretary
United Life Insurance Company

11-30-2012

Date